NRC Form 366
(9-83)

U.S. NUCLEAR REGULATORY COMMISSION
APPROVED OMB NO. 3150-0104
EXPIRES: 8/31/85

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
JAMES A. FITZPATRICK NUCLEAR POWER PLANT	0 5 0 0 0 3 3 3	1 OF 0 3

TITLE (4)

FAILURE TO MAINTAIN PRIMARY CONTAINMENT INTEGRITY

EVENT DATE (5)			LER NUMBER (6)				REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MONTH	DAY	YEAR	YEAR		SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES	DOCKET NUMBER(S)
											0 5 0 0 0
0 6	2 3	8 4	8 4	—	0 1 4	— 0 0	0 7	2 3	8 4		0 5 0 0 0

OPERATING MODE (9)		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)			
N		20.402(b)	20.405(c)	50.73(a)(2)(iv)	73.71(b)
POWER LEVEL (10)	0 0 0	20.405(a)(1)(i)	50.36(c)(1)	50.73(a)(2)(v)	73.71(c)
		20.405(a)(1)(ii)	50.36(c)(2)	50.73(a)(2)(vii)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)
		20.405(a)(1)(iii)	X 50.73(a)(2)(i)	50.73(a)(2)(viii)(A)	
		20.405(a)(1)(iv)	50.73(a)(2)(ii)	50.73(a)(2)(viii)(B)	
		20.405(a)(1)(v)	50.73(a)(2)(iii)	50.73(a)(2)(x)	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER
	AREA CODE
DOUGLAS J. LINDSEY, ASSISTANT OPERATIONS SUPERINTENDENT	3 1 5 — 3 4 2 - 3 8 4 0

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	
A	N H	I M E C	C 3 1 0	Y							

SUPPLEMENTAL REPORT EXPECTED (14)

		EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
YES (If yes, complete EXPECTED SUBMISSION DATE)	X NO				

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

During a plant shutdown with reactor pressure at approximately 650 and the reactor subcritical, a violation of primary containment occurred. On three separate occasions, totaling approximately three minutes, both the inner and outer drywell entry hatch doors were open for personnel entry and exit. This was due to a failure in the mechanical interlock designed to prevent this occurence and a failure of the personnel to recognize that primary containment integrity was violated when required at the existing plant conditions.

The short term corrective actions were:

a) Shut the doors.

b) Counsel the individuals involved.

Significant long term corrective actions include:

a) Generation of a more detailed procedure concerning primary containment entry and maintenance prior to December 31, 1984.

b) Thorough inspection of linkage to fix deficiencies during the next scheduled containment entry.

c) Retraining of personnel prior to December 31, 1984.

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FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
JAMES A. FITZPATRICK NUCLEAR POWER PLANT	0 5 0 0 0 3 3 3	8 4	— 0 1 4	— 0 0	0 2 OF 0 3

TEXT *(If more space is required, use additional NRC Form 366A's)* (17)

During a plant shutdown with reactor pressure at approximately 650 psig and the reactor subcritical a violation of primary containment occurred when required by technical specification 3.7.A.2.

Two radiological technicians had entered the primary containment for the initial entry and survey following reactor shutdown. The technicians were wearing "SCOTT" portable air breathing equipment, which is normal practice until the containment atmospheric conditions are verified safe. During the entry, no lighting was available in the air lock which exists between the inner and outer hatch doors.

While in the containment, the outer door was shut and the inner door was open. After a short time, one technician's air equipment alarm bell rang which signaled his need to leave containment. He entered the air lock and shut the inner door with the handwheel provided. Unknown to the technician, the inner door bounced slightly open and due to misalignment in the mechanical interlock between the two doors, the inner door locking plate was moved to the locked position preventing the inner door from shutting but allowing the mechanical interlock to be met and allowing the outer door to be opened. At this time both doors were open.

As the technician exited the air lock, an operator entered the air lock and shut the outer door and entered the containment by pushing the inner door inward which provided enough movement to allow the operator to pass through. The second technician exited the containment at that time in a like manner as the operator without comprehending that when he opened the outer door, that primary containment was being violated due to the inner door being ajar. A short time later, upon receiving an air equipment alarm bell, the operator once again pulled the inner door open enough to slip by and then opened the outer door for exit. Upon exit, the outer door was shut.

The basic cause of this event were the failure of the mechanical interlock to perform correctly, failure of adequate post work testing to ensure the interlock performed correctly following maintenance and failure of the individuals to recognize that drywell integrity was being violated. A critique was held and the individuals involved were counseled.

Corrective measures include:

a) Generation of a more detailed procedure concerning primary containment entry prior to the next scheduled containment entry.

b) Generation of a more detailed maintenance procedure on the containment door linkage to ensure adequate post work testing on interlock capabilities prior to December 31, 1984.

c) Training for radiological technicians and operators on the requirements of primary containment by December 31, 1984.

d) Thorough inspection of the interlock linkage to identify deficiencies during the next scheduled outage and schedule corrections as necessary.

Since personnel were always present at the door ar since the total time that both doors were open was minimal, the safety consequences of this event are minimal.

James A. FitzPatrick
Nuclear Power Plant
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New York Power Authority

Corbin McNeill
Resident Manager

July 23, 1984
JAFP 84-0707

United States Nuclear Regulatory Commission
Document Control Desk
Washington, D.C. 20555

REFERENCE: DOCKET NO. 50-333 Licensee Event Report: 84-014-00

Dear Sir:

We have enclosed the referenced Licensee Event Report in accordance with 10CFR50.73

If there are any questions concerning this report, please contact Mr. Douglas J. Lindsey at (315) 342-3840, Extension 302.

Very truly yours,

by dir. R. Cameron

CORBIN A. McNEILL, JR.
RESIDENT MANAGER

CAM:DJL:dmh
Enclosure

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